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ABSTRACT

This paper proposes and discusses, from a management point of view, application of specific outcome measurements to residential programs for mentally retarded persons and those experiencing long term mental health problems. These include: rate of restraint and seclusion; percentage of compliance with applicable standards; absenteeism/leave time usage rate for staff; client census; staffing allocation and ratios; minimum amount of active treatment; rate of protection from harm incidents; readmission rate and length of stay; internal professional review; and internal consumer/interested party review. Also identified are key client behavioral components such as level of development of socialization skills and the following four client related issues: (1) quality of life; (2) protection from harm; (3) active treatment; and (4) appropriate placement. The role of the facility manager in establishing an orderly system in which staff and clients work and live is stressed. Managers are encouraged to comply with standards, develop monitoring systems which are more stringent than those of external surveyors, develop systems to assure staff effectiveness, conduct an annual internal facility audit, and conduct random audits of specific areas of facility operation. (DB)

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SOPHISTICATION THROUGH SIMPLIFICATION-- A MANAGEMENT CONSIDERATION

William A. Lybarger

As a long term manager of Mental Retardation and Mental Health Service Systems, it has become apparent to me that we have allowed our business to become too complex. There are too many variables, too many opinions, and too many considerations. In fact, we have become so receptive to a wide span of opinions that, we have lost sight of our real objectives and how to achieve those objectives. It seems to me that sophistication can best be achieved through simplification. To do that we must set aside some of the professional biases that we accumulate as we travel through the years of training and multifaceted experience and incorporate into our style of consideration many of the precepts upon which the private sector is based, as well as a good dose of common sense. For all practical purposes, we as managers of human resource systems resemble the manager of a local Penney's, Sears or Western Auto store. We have services that are consumed. We have consumer opinions, consumer perceptions; however, we have behaved in ways that have set us aside from the straightforwardness of that external way of doing business. As I review related literature, it is frequently presented that there are a handful of key outcome measures which reflect the impact of our system in terms of client care and effectiveness. I would think that our situation is not that much different from the local McDonald's. If they produce hamburgers that taste bad, there will be a reduction in profit and corresponding reduction in a manager's salary. Managers of human resource systems have managed to develop an aura of mysticism which has led to some mistrust and protection. In fact, in some of our systems and facilities that professional mystique has restricted appropriate client care. Governors, senators, representatives, advisory and consumer groups, and families should be able to hold us responsible for quantitatively stated outcome objectives. We should be held accountable in a fairly clear cut manner. As I have reviewed relevant information, it seems that particularly for residential programs for mentally retarded persons and for those individuals experiencing long term mental health problems, there are a series of outcome measures that have particular relevance and can be defined, collected, and monitored. They could be used as tools for measuring the general effectiveness of treatment and management systems. Those outcome measures could be:

1. Rate of restraint and seclusion: A mutually acceptable definition of restraint and/or seclusion should be negotiated with facility staff. The best situation is when the definition is consistent system-wide, but facility idiosyncratic issues must be considered. Based upon the definition, a quantitative performance line should be identified for the entire facility and per unit as necessary. This measure should be reported monthly.

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2. Percentage of compliance with applicable standards: A clear cut desirable outcome is continued certification or accreditation. Toward that end, the facility should specify a desired compliance level for most standards. A reporting system should be developed which would provide this information monthly. It is necessary to add that for some standards a zero noncompliance ratio is required.

3. Absenteeism/leave time usage rate for staff: An acceptable level of leave time usage and absenteeism rate for individual or groupings of personnel classifications at the facility should be developed. Compliance figures should be reported monthly.

4. Client census: Quite possibly three different sets of information need to be reported for this issue. Projected census for the end of the fiscal year is helpful related to budget and client movement. Projected Average Daily Census (ADC) is of interest. Finally, as a facility continuum of care is developed, the number of clients in each component would be relevant and beneficial.

5. Staffing allocation and ratios: The interest in ADC is complemented by an equal interest in total funded staff allocated to the facility. Obviously, this figure is relevant to fiscal management and client well-being. Staffing allocation by profession and job function must occur. Agreement should be reached related to acceptable staff to client ratios. More specifically, the Administrators should have the cited direct care/client ratios for 90% of all shifts. Performance related to this issue should be reported monthly.

6. Minimum amount of active treatment: Each client should receive a minimum of 40 hours of active treatment per seven-day week. The definition of active treatment may differ dependent upon population served. The significance of this measure relates to the necessity of positive client interaction with the environment and with staff. In mental health facilities, and to a lesser degree in mental retardation facilities, schedules and programs are developed through a system in tune with weaknesses rather than strengths, require clients to fit programs rather than programs fit clients, and professional well-being rather than client. Active positive interaction is a necessary intervention. This measure should be reported monthly.

7. Rate of protection from harm incidents: In much the same way as rate of restraint and seclusion, this measure reflects directly on the quality of life and quantity of meaningful client to client and staff to client interaction. In addition, it is directly impacted by quantity and quality of staff. The rate of protection from harm incidents, when defined and measured consistently, sheds considerable light on facility operation. This measure should be reported monthly.

8. Readmission rate and length of stay: These issues have varying levels of significance dependent upon the client population. If the system accepts that the best services should be provided for the least cost as close to the client's home as possible which allows potential maximization and leads to independence, these variables shed light on the quality of the relationship between treatment provided and prerequisite skills necessary to move from restrictive to less restrictive environments. Semiannual reporting may suffice in this area.

9. Internal Professional Review: A significant role of a Central Office is monitoring compliance with policy. A proactive approach in this domain is ongoing internal monitoring of facility compliance in specified performance areas. At the direction and coordination of Central Office, review teams formulated with system staff should make site visits to facilities and report their findings to the Administrator and to the Commissioner. The concept of identifying problems before they become disasters is applicable here.

10. Internal Consumer/Interested Party Review: Recent professional information supports the idea that a facility and clients residing there gain when consumers make periodic review of the overall facility environment. In keeping with present philosophy that the ecology as a whole at the facility has a significant impact on quality of life, there is potential for gain by having the Administrator invite a group of individuals from the local community to tour the facility in an informal manner, share these observations with the Administrator, and then those observations be provided to the Commissioner for his information and use in evaluating overall wellness of the facility.

It is important to not let professional staff convince the doer of the preceding tasks that the process cannot be started until every variable is defined or controlled. If you wait for that, you won't do it!

I believe consistent definition, collection and analysis of this data at the facility and system level would bring to light the effectiveness of the overall operation of the facility related to client care and resource management. There are clear cut relationships well established by professional comment and activity. It is fairly straightforward that a positive activity level on the part of clients leads to a reduction most often in restriction, seclusion, and protection from harm incidents. Just the opposite, individuals clients, particularly in mental health facilities, sitting in day rooms with little or no positive activity, tend to generate more inappropriate behavior and longer hospital stays. For the most part, I believe we are well aware of these variables and factors and yet I do not believe we apply them consistently. There is an additional level of generalization that we can make related to all types of individuals experiencing handicapping conditions. That relates to five key behavioral components upon which their success in the facility or in the community is quite often based. Those are:

1. Rate of exhibition of inappropriate behavior
2. Level of development of socialization skills
3. Level of development of survival self-help skills
4. Prevocational/vocational training
5. Physical wellness

These points of reference, to a large degree, illuminate treatment activity within service systems. Look behind surveys are making it clear, and appropriately so, that there are four over-riding client related issues related to over all operation of these systems. These being:

1. Quality of life
2. Protection from harm
3. Active treatment
4. Appropriate placement

If we are to meet the challenge of doing more with less, we must be willing to apply quantitative analysis to what has been, for the most part, a qualitative experience. Those managers who are willing to face these issues with an eye to the private sector and reality will have an advantage that will carry them a considerable distance into the future struggle related to maximization of client care for minimum expenditures. The intent of my recommendations is not to restrict expression of professional training and ethics. If one will make a casual review of business related magazines and read articles related to success or failure of private enterprise and insert client for customer, you will see that there are distinct correlations and much to be learned from this type of analysis. For example, in a recent article related to People Express in the Wall Street Journal, the author stated "management specialists add that one other area needing rigorous attention even in an informally managed company is the setting of standards.

Companies have to maintain a certain level of service and have to maintain it with control. You have to set standards and see where you deviate from them." A direct result of setting outcome measures is that we establish strands of consistency in conversations which, for the most part, in the past have been based upon the concept of exceptions rather than rules. It has been my experience and quite possibly yours that one of the most difficult parts of making decisions in human services is that we are most often talking about exceptions. There is no thread to which we can cling as we lobby for exceptions; therefore, the line of right or wrong is consistently curving, bobbing, weaving, and leaving something less than an acceptable audit trail. As I mentioned earlier, my intent is not to suggest that we reduce the enjoyment level of professionals; we only ask that they practice their profession within the constraints of good management. That does not seem to be an unethical requirement. In large human service systems, how much could be saved, how many client centered questions answered more appropriately, and how many dollars better utilized if there was a consistent point of reference used in response to most of the questions. I would think that we could expect 75% of the questions in a system of this nature to be answered based upon client, facility, and system well-being. The other 25% would be based on political, media, or system idiosyncratic issues. If we were to apply a certain set of core values to 75% of the questions asked related to admissions, discharges, use of special resource funds, travel requests, typewriter purchase, duplicating machine, and contracts, we could expect an improvement in client care and achieve sophistication through simplification. The successful administrator must look beyond the walls of his/her office and become well acquainted with business practices in the real world and translate those activities into a better way of operating human service systems.

A common point of view in the area of human service systems is that treatment, good or bad, starts when client and professional or direct care staff interact. I believe that this is a misconception and one that causes considerable harm in our systems. Previous to quality of care, practice of professional skills, and expenditure of state dollars effectively, there must be order in any system. That order, to a large degree, is coordinated and initiated by the manager of that system. The most important treater at any facility is the manager.

There is a treatment ecology at all facilities treating individuals with mental retardation or mental illness and much like a classroom full of 25 students, it is quite difficult for the teacher to teach when there are 25 separate unrelated activities occurring. Order precedes learning. That order, I believe, must be established before any system can achieve a real level of sophistication. That order is generated by a work ethic and philosophy which is imperative for professionals and paraprofessionals to maximize the use of their skills. It will be

difficult for the speech therapist to practice that specific skill without electricity, a chair, or materials. Employees cannot provide treatment if they are not at work. Staff cannot contribute beneficially to staffing if they are twenty minutes late. Reports cannot be collected at a central point for individual plan development if three of the ten members are two weeks late in submitting their report. If people feel that there is no need to be at work on time, this feeling of looseness permeates a number of other components of their work day and work effort. There must be structure and order. For the most part, through the manager's attitude, philosophy, recruitment practices, and staff development this treatment/management milieu is either developed or extinguished. At any facility or agency dealing with these two particular populations, a set of expectations are enacted either intentionally or unintentionally which controls many client behaviors. Agencies or facilities serving handicapped individuals, in many ways, are no different from the external community. The police do not keep us from speeding; there are not enough of them. We understand and most of us know that the speed limit is 55, so we drive 59, but we know that if we don't go over 60, most of the radar guns will not destroy us. We don't stop at stop signs because there is a policeman at every corner. We have been conditioned as our peers expect us to stop. The situation exists related to client and staff behavior. The ecological expectations change a large number of behaviors. This is not to say that therapeutic programs, professional counseling, and professional/client interaction are not relevant. They certainly are, but their quality level is supported significantly by the expectations set forth by staff in management. Our effectiveness as treaters can be enhanced considerably by a management attitude that realizes that previous to sophistication there must be simplification. Previous to quality of care there must be order and we professionals must set aside many of the perceptions we have collected as irrelevant to our present status and unrelated to the goals of quality care. In mental retardation facilities program professionals have done much toward serving the client and not their particular professional affiliation. This can be seen in the development of qualified mental retardation professionals. There is in fact a demand right now for a generic professional as we move toward provision of training activities in the normal flow of a client's day. We are becoming more and more dependent upon individuals who have the capacity to take a situation and achieve training for individual gain which are not specifically identified in a written plan. This requires a tremendous amount of flexibility and is very demanding. Many of our professionals with a narrow scope to their training and experience are finding themselves in difficult situations. In some mental health systems there is a concerted effort being made to expand the array of acceptable treatment modalities. Mental health systems for the most part have not achieved the loss in professional identity which has occurred in mental retardation areas. Professionals serving professions is one of the most significant barriers present. This

leads full circle, I believe, to our original point. There is a core set of outcome measures which represent values for the system. If those outcome measures are applied consistently, many of the barriers which have prevented effective client care will be abandoned.

Finally, all of the preceding revolves around and permeates the issue of facility operation in a way which, through effective use of resources, client well-being and treatment are enhanced. The most direct contingency is the potential for decertification. The most foreboding deficiency of all is lack of active treatment. When you are out of compliance in this domain, for all practical purposes you are out of compliance in general. As preceding comments would indicate, active treatment is not the first issue. In fact, it is the icing on the cake. The administrator who decides to implement active treatment must begin with issues, concerns, correction, and value alteration which seem quite distant from active treatment. A good place to start is with maintenance, security, dietary, and housekeeping. Protection from harm involves compliance with external factors which put the facility or client at risk. This risk can range from fire, tornado, toxic chemicals, or a direct care recruitment process which allows crooks, murderers, and/or rapists to work with clients. Dietary staff have a significant impact on client behavior and staff morale. Cold food, ugly food, sarcastic food servers, and/or dietitians more concerned with calorie count than clients consuming food in the most normalizing atmosphere which is aesthetically pleasing can offset the work of a number of psychologists. Maintenance workers play a large role in producing an environment which allows the provision of active treatment. The appearance of the grounds, painted walls, clean cars, and trimmed sidewalks not only impact client and staff behavior, but set the tone for appropriate professional behavior. Finally, housekeeping services and staff are not only important to compliance but provide a foundation for effective operation. People feel better and work better in a clean structured environment. Consumers and interested parties may not understand the interdisciplinary process, but they understand clean.

There is a broad spectrum of attitudes that must be in place for a facility to provide active treatment at a consistent level for an extended period of time. A number of administrators can stimulate short term behaviors required to pass a survey. However, facilities whose operational mode is tied to external monitoring only will experience peaks and valleys of emotion and effort which will eventually consume more psychic energy than required to develop good programs and effective operation. Key management issues are:

1. Don't try to avoid the issues. The facility must comply with the standards. All staff should be trained in standards which apply to them.

2. Develop monitoring systems which are more stringent than external surveyors. The Administrator should be the facility's chief surveyor.

3. The key to consistent application of active treatment and compliance is the development of systems which assure that staff complete work in a quality manner promptly and consistently. Monitor and publish reports describing projects completed on time, staff late for staffings, and departmental compliance with standards.

4. Have a facility internal audit annually which is comparable in scope and intensity to external audits. Use the standards as a point of reference in decision-making. The more the issues permeating the standards are incorporated into daily operation the less surprises
occur during surveys.

5. The Administrator should make random audits of client records, client living areas, and other areas of operation.

Quite possibly the final layer preceding provision of care and treatment of consistent quality is incorporated in the attitudes, values, and performance of professional staff, department heads, and executive staff. This group of individuals must be expected to behave somewhat differently than taught in their professional preparation.

Finally, the real trick is to specify outcomes, consistently monitor performance related to those outcomes, and provide sufficient organizational and environmental structure such that staff can apply their skills and generate an ecology which enhances clients' integrity and humanism, but expects behavior consistent with potential.

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